

September 18, 2000

PRELIMINARY NOTIFICATION OF EVENT OR UNUSUAL OCCURRENCE PNO-II-00-34

This preliminary notification constitutes EARLY notice of events of possible safety or public interest significance. The information is as initially received without verification or evaluation, and is basically all that is known by Region II staff (Atlanta, Georgia) on this date.

<u>Facility</u>	<u>Licensee Emergency Classification</u>
Phillip Morris, U.S.A.	Notification of Unusual Event Alert
Richmond, Virginia	Site Area Emergency
Dockets:	General Emergency
	X Not Applicable

Subject: FAILURE OF SHUTTER MECHANISM TO FULLY CLOSE ON A GENERALLY LICENSED DEVICE

This notification provides additional information for a September 6, 2000, report to the NRC Operations Center. On September 6, the licensee reported an event that was identified during a routine inventory conducted on June 1, 2000, regarding the failure of a manual shutter mechanism to fully close on a generally licensed device.

The device is an Industrial Dynamics Company, Inc. Model No. FT-14 fill level and density gauge containing two americium-241 sources, 100 millicuries each. On February 18, 2000, the licensee removed the gauge from the production line. During the removal of the gauge the licensee removed the source holders that contained the two sealed sources and placed the source holders in a secured and shielded storage location. During a routine inventory of the storage location the licensee identified an elevated radiation level higher than background and determined that the manual shutter mechanism had not fully closed in the shielded position.

The licensee conducted an investigation and determined that a piece of lead on the device had become loose and lodged in the path of the manual shutter mechanism preventing it to close in the fully shielded position. The individual who removed the device and handled the source holders was monitored with whole body and extremity personnel radiation exposure dosimeters and had received no measurable occupational radiation exposures. Also, the licensee determined that individuals who may have been working in or near the area of the device received no measurable radiation exposures when the sealed source was partially exposed.

The licensee has contacted the manufacturer of the device to determine what could have caused the piece of lead to become loose. The licensee is still reviewing the circumstances surrounding the failure of the manual shutter to close and will submit a formal report to the NRC within the required 30 days.

RII will followup on this event during the next routine scheduled inspection of the licensee. This information has been discussed with the Commonwealth of Virginia and is current as of 10:00 a.m., September 8, 2000.

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